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	HFD12-0076	A. BUILDING _____ B. WING _____	05/18/2010

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I 000	INITIAL COMMENTS A re-licensure survey was conducted on 5/18/2010. Six males with varying degrees of disabilities reside in the GHMRP. Three of the six residents were selected for the survey sample. The findings of the survey were based on observations at the group home, interviews with the GHMRP ' s staff, and the review of GHMRP's records including the incident reports.	I 000	Maintenance was notified on 5/18/10 that the sink appeared to be leaking. Upon observation it was discovered that the garbage disposal was causing the leak. The maintenance department immediately purchased the part to repair the leak and the problem was resolved. Since the repair the area has been checked on a daily basis and no other leakage has been noted. In the future the House Manager will ensure that routine checks occur under the sink to ensure that the kitchen sink is maintained without needed repairs. Received 8/13/10 DOH HRLA-1000	5/18/10
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and staff interview, the GHMRP failed to ensure the maintenance of a safe, clean, orderly, attractive and sanitary environment to ensure the health and safety of its six residents. The findings include: During the environmental inspection on 5/18/2010 at 10:20 a.m., the plumbing in the kitchen sink began to leak. The water filled the lower cabinets and out on to the kitchen floor. The GHMRP ' s maintenance wes called out to the home and his inspection revealed a problem with the connection between the garbage disposal and the dralnage pipes. Later on at approximately 3:30 p.m. in the aftemoon, the piping in the kitchen sink began to leak again. Interview with the GHMRP ' s maintenance staff	I 090		

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I 090	Continued From page 1 on the same day at approximately 11:30 a.m., revealed the piping below the sink was a recurring problem and that he would have to reassess the problem to find a permanent solution. Interview with the GHMRP ' s House Manager on the same day at approximately 4:40 p.m. confirmed the drainage system for the kitchen sink was a recurring problem and that they are working to find a solution.	I 090	The area under the cabinet was cleaned and disinfected with a bleach base solution to prevent mold accumulation. All cleaning and chemical agents have been removed and put in a locked cabinet in the laundry room. Staff has been in-serviced on the proper storage of cleaning agent to ensure continued compliance.	5/19/10
I 096	3504.7 HOUSEKEEPING No poisonous or hazardous agent shall be stored in a food preparation, storage or serving area. This Statute is not met as evidenced by: Based on observation and staff interview, the group home for the mentally retarded person ' s (GHMRP) failed to ensure no poisonous or hazardous agents were being stored in the kitchen. The finding includes: During the environmental inspection on 5/18/2010, at 10:25 a.m., several bottles of oven cleaner, surface cleaners and bug sprays were being stored in the cabinet below the kitchen sink. Interview with the GHMRP ' s House Manager on the same day at approximately 10:26 a.m., confirmed the kitchen should remain free of any chemical agents. The HM further added, she would retrain staff to ensure they understand that no chemical agents should be stored in the kitchen.	I 096		

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I 180	Continued From page 2	I 180	1. Staff has been trained in first aid and CPR. All certifications are now current and can be found in each staff permanent records. 2. The DDS Service Coordinators are now responsible for writing the ISPs and are the point of contact for the finalized assessments to be triaged through prior to them being placed in the individual's ISP's. The DDS Service Coordinator has been contacted regarding placing assessments with electronic signatures in the individual's ISPs. All consultants have been notified to re-submit their assessment with their handwritten signatures. Once received they will be placed in each individual's records. 3. The RN has since in-service staff on each individual's feeding protocol. The Nutritionist has been contacted to review and update all protocols and will train staff after completion. 4. Staff has been in-service on all mealtime protocols. In the future staff will be observed during mealtime to ensure they are following all protocols.	6/30/10
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for the mentally retarded person ' s (GHMRP) qualified mental retardation professional (QMRP) failed to ensure the coordination of services to promote the health and safety of two of three sampled residents. [Residents #1 and #2] The findings include: 1. The QMRP failed to ensure all currently employed staff had a valid first aid or cardiopulmonary resuscitation (CPR) certifications on file. [See 3510.5] 2. The QMRP failed to ensure all documents presented as part of a resident ' s habilitation plan were submitted into record with a valid signature and date. [See 3514.2] 3. The QMRP failed to ensure all residents received their medications in the form outlined in their feeding protocols. [See 3520.2(e) 4. The QMRP failed to ensure all residents was provided the measure of support outlined on their mealtime feeding protocols. [See 3523.1]	I 180		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following:	I 227		

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I 227	Continued From page 3 (d) Emergency procedures including first aid, cardiopulmonary resuscitation (CPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure all staff was currently certified to perform first aid and cardiopulmonary resuscitation (CPR) procedures as required by this section for six of fifteen staff. [Staffs #3, #5, #6, #9, #10 and #11] The finding includes: Record review and interview with the GHMRP's qualified mental retardation professional (QMRP) and the house manager (HM) on 5/18/2010, at approximately 5:30 p.m. revealed there was no evidence on file to substantiate that six out of fifteen staff ware certified to perform first aid and CPR procedures.	I 227	All staff now have current first aid and CPR certifications and can now be found in their files. In the future the Support Coordinator and House Manager will check the records on a regular basis to ensure that certifications are updated prior to there expiration date.	6/30/10
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure all individual program plans filed into a resident ' s habilitation record was signed and dated by the consultant who drafted the assessment for one of three sampled residents. [Resident #2]	I 291		

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I 291	Continued From page 4 The finding includes: The facility failed to ensure all entries into a resident ' s record was validated by signature and/or date. An example of the deficient practice is provided below: Record review on 5/18/2010, at approximately 2:20 p.m. revealed, Resident #2 ' s Jan-March 2010 Psychological assessment was neither signed nor dated by the consultant who drafted the document. Interview with the GHMRP ' s qualified mental retardation professional (QMRP), the house manager (HM) and the GHMRP ' s nurse on the same day at approximately 2:25 p.m. confirmed several of the consultant ' s assessments were being submitted without a valid signature or date.	I 291	All assessments have now been replaced with assessments with valid handwritten signatures and dates. The Support Coordinator has replaced individual's #2 assessments with a signed and dated assessment. In the future the Support Coordinator will work closely with DDS Service Coordinator to ensure that all assessments are signed and dated by the consultants as well as to ensuring that all assessments are not submitted with electronic signatures. All assessments have now been replaced with assessments with valid handwritten signatures and dates.	6/30/10
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for the mentally retarded	I 395		

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I 395	Continued From page 5 persons (GHMRP) failed to ensure its nursing staff correctly implemented the prescribed medication orders and the proactive strategies outlined in a resident ' s habilitation record for two of three sampled residents. [Residents #1 and #3] The findings include: 1. The GHMRP ' s nurse failed to administer medications in accordance with the physician ' s orders as evidenced below: a. Observation on 5/18/2010, at 8:15 a.m. revealed, the attending nurse filled a small measurement cup with Tegretol to administer to Resident #3 for his morning medications. Just before she administered the medication, this surveyor requested that she check the amount that was poured. Upon further inspection, she confirmed approximately 35cc of Tegretol was poured because it overflowed the 30cc mark and filled the small measuring cup to the rim. The attending nurse further confirmed that she over poured the Tegretol because she wanted to account for the " bubbles " that foam up when the medication is poured. The nurse then poured out the excess medication into the sink at the nursing station Review of Resident #3 ' s 5/1/2010 Physician Order Sheets (POS) at approximately 8:45 a.m., revealed the prescribed dosage of Tegretol was 30cc. b. Observation on 5/18/2010 at 8:15 a.m., revealed the attending nurse poured 20cc of Atarax into a small measuring cup to administer to Resident #3. Upon further inspection, she confirmed via the medication administration	I 395	The cited nurse has been in-serviced by the director of nursing regarding all aspects of medication administration. The nurse also received counseling regarding her medication administration techniques that resulted in these citations. Coupled with the cited nurse being counseled all nursed in the home has also been trained to ensure that everyone is administrating medications per the Physician Orders, medication policies, and feeding protocols. In the future, the DON will monitor medication administration at least once weekly to ensure that medication administration protocols are being implemented as prescribed.	5/19/10

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I 395	Continued From page 6 record, that the dosage should have been 12.5cc. Review of Resident #3 ' s 5/1/2010 Physician Order Sheets (POS) at approximately 8:45 a.m., revealed the prescribed dosage of Atarax was 12.5cc. c. Observation on 5/18/2010 at 7:52 a.m., revealed the attending nurse administered 50 mg of Synthroid to Resident #5. Interview with the attending nurse and review of Resident #5 ' s Physician Order Sheets (POS) on the same day and time confirmed, Resident #5 ' s Synthroid was prescribed as " take 1 tab at bedtime by mouth " . 2. The GHMRP ' s nurse failed to correctly implement the resident ' s feeding protocols as evidenced below: a. Observation on 5/18/2010, at 7:40 a.m. revealed, the attending nurse provided Resident #2 his medications with approximately 6-8oz of juice in a small Styrofoam cup. She allowed Resident #2 to hold his cup and drink his juice after ingesting his medications. While he drank his juice, he coughed slightly but was able to finish. On his last gulp, he began a series of loud, gurgle sounding coughs. His eyes slightly watered during the short coughing episode. The attending nurse patted him slightly on his back and indicated that he obviously consumed his drink too fast. A quick interview with the nurse at the same date and time revealed Resident #2 generally is a fast drinker. Record review on the same day at 2:33 p.m. revealed Resident #2 ' s Mealtime Feeding Protocol dated 1/7/2009 revealed the following:	I 395	New medication cups have been ordered and are now being used. The new cups are easier to read. Dosage amounts are clearly labeled and easier for one to measure. (see attached picture of the new medication cup)	5/19/10

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I 395	Continued From page 7 " It is very important that [Resident #2] drinks from a cup with a small opening (to restrict flow of liquids) since he has a tendency to gulp liquids while extending his head back. This causes him to cough when drinking from a regular cup. " b. Observation on 5/18/2010, at 8:15 a.m. revealed, the attending nurse opened the small medication capsule of Prilosec (20mcg) and poured the contents into a small crusher. After she crushed the small beads of Prilosec she poured it into a small measuring cup and mixed it with approximately 5cc of water. At the start of her administering Resident #3 his medications, she reached under his shirt and pulled out his G-Tube to check for residuals. After the residual ' s check, she began to administer the morning medications by first pouring the mixture of Prilosec and water into the plastic syringe she attached to the end of the G-Tube. The mixture had a difficult time going down the G-Tube. She shook the syringe slightly and the mixture started to slowly run down the line. At this point, she poured 5 ml of Vitamin C into the syringe and then poured 5cc of Thera liquid into the syringe to continue on with administering the medications. All of the Thera liquid did not pour out, so the nurse poured water into the small measuring cup and then poured it into the syringe in effort of administering as much of the Thera liquid as possible. She repeated that step twice more. Once that grouping of medications made its way down the G-Tube, she continued with administering the rest of the medications. Record review on the same day at approximately 8:30 a.m., revealed Resident #2 ' s G-Tube	I 395	The Director of Nursing has completed a thorough training with all nurses in the home on G-Tube feeding. G-Tube feeding will be observed by the Director of Nursing on a daily basis to ensure that the feeding is being completed as ordered and to ensure that the individual is safely being administered his feedings. The cited nurse has been counseled on her feeding practices and the counseling papers can be found in her permanent records.	5/19/10

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I 395	Continued From page 8 medication administration protocol dated 12/30/2008 prescribed the following intervention: " The basic procedure ... 1) Measure 60 cc of water into a measuring cup. 2) Prepare the required amount of medication. 3) Uncap the G-tube and check for placement of the G-tube as instructed above. 4) Check for stomach residual as instructed above and follow the instructions for less than or more than 60 cc residual. 5) Pour half the water into the syringe to flush the tube. 6) Pour the medication into the syringe. 7) Pour the remaining water to flush the tube. If you give more than one medication at the same time: Have 60 cc of water ready in a measuring cup. Flush the tube with 10 cc of water - give medication - flush with another 10 cc of water - give next medication - flush with 10cc water, and so on and flush with 60 cc of water after all medication. Do not mix liquid medications together to administer them. Give water, then the first medication, then water, then the second medication, then water. The rule is to give water first and last, and between different items. Always flush the tube with plain water after all other items have been administered. " Interview with the attending nurse on the same day at approximately 8:55 a.m., confirmed she failed to alternate water with the administration of each of the first three medications and also failed	I 395	All nurses in the home have been trained and will continue to be trained on a regular basis on medication administration by the Director of Nursing. Trainings and medication administration observations will occur weekly for one month to ensure compliance with the physician orders, medication protocols and policies as well as the feeding protocols of all of the individuals. An intense training on measuring medications prior to administration has been completed by the Director of Nursing.	5/19/10

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I 395	Continued From page 9 to measure 10 cc per flush in between the remaining medications.	I 395	The Behavior Specialist and Psychologist have been contacted regarding this citation. A formal protocol has now been developed after the review of the documentation regarding this behavior. The protocol is now in place and the staff has been trained on the 'Proactive Protocol'. Staff will be monitored on an ongoing basis to ensure that the protocol is being implemented as written.	6/30/10
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to provide evidence that assessments to address a client ' s " deliberate regurgitation " was completed for one of three sampled residents. [Resident #2] The finding includes: The GHMRP failed to ensure the creation of a Proactive Strategy/Behavior Support Plan to manage a resident ' s " deliberate regurgitation " as recommended in Resident #2 ' s 6/15/2009 Baseline Summary Note written by the attending Psychologist as evidenced below: Observation on 5/18/2010 beginning at approximately 3:00 p.m., Resident #2 was observed sticking his hand/fingers into his mouth repeatedly on several occasions. Record review on 5/18/2010 at 3:21 p.m. revealed Resident #2 ' s Baseline Summary Note provided the following assessment: " During the course of visits to [Resident #2 ' s]	I 401		

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I 401	Continued From page 10 home made by this consultant, the Designated Nurse (DN), and members of his direct care team raised the issue of his apparent deliberate regurgitation ... A baseline data collection sheet was developed and staff members were advised on its use. Between February 21 and April 9, 2009, 15 incidents were documented ... When they occurred, some staff members verbally intervened, directing him to stop while others supplemented the verbal direction with a change in activity or area. The latter form or intervention was the more effective technique. The concern of this consultant was that neither appropriate proactive support nor appropriate intervention had been universally applied ... it appears that a consistent method of discouraging regurgitation is necessary. " Further record review on the same day at 3:23 p.m. revealed Resident #2 ' s Psychological Assessment dated 12/3/2008 further recommended " the development of a BSP to address [Resident #2 ' s] tendency to place his hands in his mouth, which frequently results in regurgitation. " Interview with the GHMRP ' s qualified mental retardation professional (QMRP) on 5/18/2010, at 5:21 p.m. revealed, the " proactive strategy " was not available for review and the creation and implementation of it was still pending. The QMRP further established that she had to communicate with the Psychologist to find out if it was still a valid pursuit. There was no documentation on file at the time of survey to substantiate that the proactive strategy	I 401	The Behavior Specialist and Psychologist have been contacted regarding this citation. A formal protocol has now been developed after the review of the documentation regarding this behavior. The protocol is now in place and the staff has been trained on the `Proactive Protocol'. Staff will be monitored on an ongoing basis to ensure that the protocol is being implemented as written.	6/30/10

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I 401	Continued From page 11 to manage Resident #2 ' s deliberate regurgitation was created as recommended.	I 401	Staff has been in-serviced on the importance of remaining by each individual during mealtime. The Nutritionist has also been contacted to conduct an in-service to stress the importance of following diet orders and mealtime assistance. The staff will continue to be monitored closely by the all management team members to ensure that they are adhering to all mealtime protocols.	7/1/10
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for the mentally retarded person (GHMRP) failed to ensure the accurate implementation of resident ' s mealtime feeding protocols for one of the three sampled residents. [Resident #2] The finding includes: On 5/18/2010 at during breakfast at 7:23 a.m., and again on the same day at approximately 11:40 a.m.,, Resident #2 was observed eating his meal with no staff intervention. Resident #2 received cream of rice, chopped bacon, a serving of applesauce and a milk in a medium sized spout cup. During breakfast he was observed scooping large spoons of the cream of rice mixed with the bits of bacon into his mouth. He ate at a steady pace, but finished rather quickly. At the end of his meal, he attempted to drink his milk, but unfortunately was drinking out of the wrong side of the cup. A good portion of his milk spilled over his bib and onto the table and on his lap. No staff was attending to him and did not see the difficulty he was having with drinking his milk. As with his lunch, he was allowed to consume his meal with no staff intervention. Record review on the same day at 2:33 p.m. revealed Resident #2 ' s Mealtime Feeding	I 422		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 12 Protocol dated 1/7/2009 provided the following Techniques for Eating and Drinking: " [Resident #2] should be encouraged to use multiple swallows and alternate drinking and eating to decrease food residue post swallowing. It is very important that [Resident #2] drinks from a cup with a small opening (to restrict flow of liquids) since he has a tendency to gulp liquids while extending his head back. This causes him to cough when drinking from a regular cup ... Staff should verbally cue [Resident #2] to put less food on his spoon/fork. He should have no more than ¾ of a spoonful of food in his mouth at a time. " Interview with the GHMRP ' s house manager (HM) and the qualified mental retardation professional (QMRP) revealed they were not aware the staff allowed Resident #2 to eat his meals without any direct intervention.	I 422	All staff have been trained on the importance of monitoring mealtimes and the individuals. They have been instructed to remain at the table until meals have been consumed by each of the individuals. Each individual in the home are now being directly monitored during meals in order for them to receive intervention from the staff if warranted.	7/1/10
I 473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for the mentally retarded person (GHMRP) failed to ensure all medication irregularities were reported to the prescribing physician. The finding includes: On 5/18/2010, several medication errors were observed during the administration of the morning medications. At the end of the morning	I 473		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0076	A. BUILDING _____ B. WING _____	05/18/2010

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I 473	Continued From page 13 medication pass, the medication administration record (MAR) and the medical records were reviewed. There was no evidence presented or on file at the time of the survey to validate that the prescribing physician was made aware of the irregularities that transpired during the morning medication pass. [See 3520.2(e)]	I 473	The Director of Nursing have since contacted and met with the prescribing Physician regarding the medication pass. The Director of Nursing was advised about the most effective course of correction regarding the medication pass. All recommendations have been implemented. The DON has documented her communication with the physician in her nursing notes.	5/19/10